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CARDIOVASCULAR DISEASE
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GASTROENTEROLOGY
WM. DEAN ASHWORTH, M.D.

June 8, 1970

Raymond Green, M.D.
Heber City, Utah

RE: Mrs. Dortha Dayton

Dear Ray:

I apologize for the delay in bringing you up to date on Mrs. Dayton. I am sure you recall her long history of what would appear to have been a mild bronchial asthma. She admits to have been an extremely nervous, anxious lady. She began to complain of mild abdominal distress which dated back several months. She was seen by Dr. Leland K. Dayton in Provo who apparently came up with no real definite pathology. She was again hospitalized in Provo under his care and Dr. Crisp, a Psychiatrist, apparently because of the persistence of many of her unexplained symptoms and because of depression and she was given a series of electro-shock treatments. She feels that these aggravated her condition.

I first saw her in the office in early April. At this time a complete examination was essentially non-revealing. I must say I suspected that most of her symptoms were functional and that we would probably come up with no definite answer. She wanted to visit relatives in Las Vegas prior to our completing the work-up. By the time she returned for further evaluation she was feeling a good deal worse. Nausea and abdominal pain seemed more prominent. She, likewise, had noted som icterus, dark urine and light colored stools. This certainly changed the complexion of things. At this point I wondered about a Thorazine induced hepatitis, infectious hepatitis, etc. We put her through a complete G.I. work-up, x-raywise, and found nothing abnormal. She was then hospitalized and had the rather classic biochemical features of an obstructive jaundice. Again we were thinking along the lines of a possible Thorazine induced toxic hepatitis. However, when the bilirubin continued to rise and there was no improvement otherwise, we felt that surgical exploration was mandatory.

Accordingly, on 1 May, 1970, Dr. H. M. Jackson did an exploratory and found a small tumor encircling the common duct which was within the substance of the pancreas. He carried out a chole-cystojejunostomy and closed. After considerable consideration

we elected to re-operate. This was after considerable consultation and discussion with her family. Accordingly, on 7 May, 1970, Dr. C. R. Ford did a Whipple procedure. Her postop course was quite smooth except for the presence of a Staph incision infection. We had her on rather heavy doses of Keflin and Loridine.

It was of interest that she initially had slight glycosuria and hyperglycemia. We wondered with the partial pancreatectomy that she might be an overt diabetic. It was also noted that the pancreas was somewhat fibrotic at the time of surgery. However, this sugar problem was only short-lived and throughout the rest of the hospital course there was no evidence of hyperglycemia or glycosuria.

Mrs. Dayton continued to have some feeling of tightness and pressure in her chest. I still think that this is a tension kind of symptom. At no time have I heard any wheezing. She was also complaining of occasional diarrhea. Also, there was some abdominal fullness. At the time of her discharge she was still losing some weight. At the present time Dr. Ford is following her. We discussed putting her on some pancreatic enzyme and some mild sedative.

I would think there is a reasonable good prognosis on Mrs. Dayton. There was no evidence of liver involvement. The adjacent lymph nodes were negative for tumor. I will have Dr. Ford appraise you of any further developments.

Again thanks for this most interesting case. I certainly can't be critical in any way of her previous management since certainly her symptoms did suggest functional disease. I suppose we were lucky to find definite evidence of disease and hence got on the right track.

Best personal regards.

Very truly yours,

TED B. BERNHISEL, M.D.

TBB:fm